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December 3, 2007

MEMORANDUM

TO:

Legislative Oversight Committee Members	Commission for MH/DD/SAS
Local CFAC Chairs	State CFAC
NC Council of Community Programs	NC Assoc. of County Commissioners
County Managers	County Board Chairs
State Facility Directors	LME Directors
LME Board Chairs	DHHS Division Directors
Advocacy Organizations	Provider Organizations
MH/DD/SAS Stakeholder Organizations	NC Assoc. of County DSS Directors

FROM: William W. Lawrence, Jr., MD

Mike Moseley

SUBJECT: Implementation Update #37: Medicaid Billing Errors and Modifiers, Appeals and Authorizations, Endorsement Policy Revision, Attachment Disorder Guideline Development, and Staff Qualification Guidance

Common Billing Errors

The Division of Medical Assistance (DMA) has been working with Electronic Data Systems (EDS) to review provider billing practices to identify repeated errors on provider claims that might prohibit payment. There remain a large number of problems being submitted on claims that are the provider's responsibility to ensure accuracy and completeness. Below is a list of the most common problems:

- Matching Provider Numbers -- The provider number on the In-patient Treatment Report (ITR) and claim must be identical for the claim to process. In a recent one week period, over 200 providers submitted an unknown provider number, a provider number that does not match the service code, or a provider number that was different than the one submitted for authorization. Any difference between provider numbers will cause the claim to be denied.
- Including the Appropriate Modifiers with Procedure Codes – For the majority of service codes, there are specific modifiers that must be included to identify correct rates, service populations (adult/child), etc. This must be included on both the ITR and claim; claims will be denied if there is not a match. Please remember that for Medicaid, adult services begin at age 21.
- Matching Dates of Service – In a review of claims paid for a recent one week period, approximately 30% of claims did not fully match dates of authorization. We recognize that provider data systems used for claims submission may not incorporate authorization dates; however any differential between dates will result in the claim being denied.

Too often these issues are reported as problems with Value Options authorization or EDS payment systems. DMA has directed EDS to require providers to cite the Explanation of Benefits Reason Codes for denial of payment whenever inquiries are made. This will allow more effective responses to your questions.

New Denial Codes on Explanation of Benefits (EOB)

Effective with the December checkwrites, providers will see new EOB denial codes. The following codes are associated with prior approval.

- EOB 2610 - All unauthorized units have been exhausted. Prior approval is now required
- EOB 2621 - Service denied. Units have been exceeded for POS 01 per 30 days
- EOB 2639 - Units cutback. Maximum of 80 units allowed for POS 01 per 30 days
- EOB 2622 - Service denied. Maximum units allowed per day have been exceeded
- EOB 2638 - Units cutback. Maximum of 96 units per day have been exceeded

Community Support Modifiers

As noted in the November 2007 Medicaid Bulletin and Implementation Memo #36, providers must report the qualification of the staff providing community support services. Community Support Modifiers U3 and U4 are required to report the level of staff and must occur on submitted billing effective with December 1st date of service. This reporting via CMS-1500 to EDS is not related to authorizations from Value Options. EDS has made modifications in the claims processing system to accommodate this reporting requirement. Below are guidelines to assist providers in accuracy of claims submission:

- Providers should bill only one line each for U3 or U4 services per date of service per client. If more than one QP or non-QP provides services on the same date, these staff units should be rolled into one detail line – one line for U3 and one line for U4.
- It is expected that QP and non-QP time may be billed on the same date of service.
- The determination of what qualifies as QP or non-QP time is dictated by the staff providing the service, not the actual intervention.
- The maximum of 32 units per day per client is applied to the combined U3 and U4 units of service.

All inquiries concerning this reporting should be directed to EDS or DMA Provider Services staff. New EOB codes to assist in explaining errors are as follows:

- EOB 2109 – Requires secondary modifier of U3 or U4 (omissions)
- EOB 2110 – Secondary modifier is in the wrong position

Reminder: Whenever two staff members are providing services in unison, only one staff person's time is billable. For example, when the QP and non-QP are both participating in a treatment team meeting, only one staff may bill. This has been the long-standing rule in Medicaid service delivery which is based upon client time in services, not staff time.

Hearings & Appeals

There has been a great increase in the volume of client appeals based upon authorization denials or service modifications. All submission of requests for hearings must come from the client or his/her legal representative, as appropriate. Providers may not sign the appeal request form on behalf of clients requesting a hearing or have clients who have been adjudicated incompetent and have legal representatives sign the appeal request form. These cases will be automatically dismissed before the hearing date for all OAH Hearings.

When the Hearing Office receives a client appeal, Value Options automatically initiates Maintenance of Services* (MOS) until the hearing occurs. At the time a decision is rendered, Value Options will implement the level of service as ordered. The provider does not need to submit a new request. The provider may check the authorization timeframes through Provider Connect.

There will be approximately a 2 to 3 week time lag between the notification to the Hearing Office and the entry of the maintenance of service authorization. If providers attempt to bill claims before the MOS authorization is entered, these claims will be denied. Providers may choose to check with EDS to verify that this authorization is present prior to billing.

*Maintenance of Services: Services should be continued at the level being provided at the time of the denial, reduction, or termination or at the level requested by the provider, whichever is less, if so desired by client and/or his/her legal guardian.

MOS is only granted for consumers receiving the service being reduced or terminated. Initial requests are not eligible for MOS.

Authorization Timelines

Many providers are receiving denials for services based upon the lack of information submitted. The revised requirements and associated timelines for authorization have been posted on the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) web site since July under the Accessing Care Training. Please refer to the Authorization Timelines grid for both direct and indirect admission services. These clarify the requirements for Person Centered Plan and ITR requests.

Revised *Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services*

Based on feedback from LME(s) and providers, the *Policy and Procedures for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services* has been revised to provide additional clarification. A summary document indicating changes and clarifications to the policy, a standard *"POC Required" letter* (required per the revised policy) and a revised NEA letter are posted on the DMH/DD/SA website www.ncdhhs.gov/mhddsas. The revised policy is effective **December 3, 2007.**

Attachment Disorder Guideline Development

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services recognizes the importance to and impact on families and their children who have been diagnosed with Attachment Disorders. Such disorders are extremely rare, as is the expertise to diagnose and appropriately treat this condition. In order to provide guidance to the field on this matter, the Division has been working with the Duke University Center for Child and Family Studies to develop guidelines for the treatment of Attachment Disorders. The Duke Center in conjunction with other nationally recognized experts on Attachment Disorder have developed guidelines and are working with DMA to institute these guidelines into policy in accordance with Medicaid's regulations for establishing medical/clinical policy.

In addition to an overview of Attachment Disorders, the guidelines will address Principles of Diagnosis and Treatment of Attachment Related Disorders, Diagnostic Criteria, Role of the Caregiver, Controversies in Diagnosis and Treatment and Assessment Guidelines, Treatment Guidelines, and Use of Evidence Based Treatment Approaches. One of the suggestions made, given the extreme rarity of the disorder, is the use of a second opinion when a diagnosis is made. While there is no requirement at this time for a second opinion, it is encouraged in order to clarify and recommend a treatment plan for this complex diagnosis.

Once these guidelines become policy, they will be distributed to relevant parties to ensure that proper support and guidance are available. As part of its contract with the Duke Center, the Division has developed the opportunity for community providers to seek a second opinion when attachment disorder is believed to have been found. Medicaid may not limit the choice of assessment or treatment to a particular provider but does require that any recommendations or assessments be completed by clinicians who have the clinical expertise to diagnose and treat these disorders.

In summary, these guidelines will be recommended clinical practices and have not yet been formally promulgated through DMA clinical policy procedures. DMA will instruct their utilization review contractor, Value Options to use the guidelines as a foundation for making medical necessity decisions once these guidelines are established as clinical policy.

Staff Qualification Guidance

Appendix A is guidance drafted by the Staff Qualifications Workgroup, established by the Division of MH/DD/SAS in response to a request from the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services, for the purpose of reviewing and revising the administrative rules governing Staff Qualifications, specifically 10A NCAC 27G .0104: Staff Definitions, 10A NCAC 27G .0203: Competencies of Qualified Professionals and Associate Professionals, and 10A NCAC 27G .0204: Competencies and Supervision of Paraprofessionals. The workgroup has members from DHHS, provider organizations, Local Management Entities (LMEs), and consumers and families.

It has become apparent that some of the language in the current rules has been interpreted differently by staff of LMEs and provider organizations. As a first step to revising the current rules, the workgroup discussed the concept of "experience with the population being served" – which is the phrase in the current rules that has been most subject to variations in interpretation. In an effort to standardize the interpretation of this phrase until revised rules are approved and implemented, the workgroup has developed the attached policy guidance. This document, in a question and answer format, outlines the DHHS interpretation of this concept.

Unless noted otherwise, please email any questions related to this Implementation Update to ContactDMH@ncmail.net.

Appendix

cc: Secretary Dempsey Benton
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Appendix A

Experience with the Population Served

1. *Who is the "population served" for the purposes of staff experience and practice? Issues for consideration: age categories, disability areas, and co-morbidity.*

   - For Mental Health, Developmental Disabilities and Substance Abuse, "population served" should be considered as the three population groups with age or developmental level of the individual served for the purposes of determining staff experience and practice

2. *What is the definition of "experience" for experience with the population served? Issues: Is full-time experience required, must it be supervised, does management experience count, should the time credited be pro-rated in some situations, does experience need to be in a clinical setting?*

   - Experience does not have to be full time but should be calculated as full time equivalent (FTE) (i.e., if someone has worked for 4 years half time that would equal 2 years of experience). Experience with a dually diagnosed population would count 100% in each area for the period of time worked. Mixed caseloads with different populations would be evaluated based on functions and tasks during that time to determine the experience gained in each population.
   - A Qualified Professional for substance abuse who is not a licensed professional or a certified substance abuse counselor must meet one of the following:
     i. has a Masters degree in a human service field and one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling or;
     ii. has a bachelor's degree in a human service field and two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or
     iii. has a bachelor's degree in a field other than human services and four years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

   - Determination of "experience with the population" should be focused on the functions and tasks performed within those areas of previous experience that correspond to the functions and tasks required in the service definition. Special education, child protective services, and some correctional programs are examples of some of the many settings that individuals could obtain experience with individuals in the target populations if the area of responsibility included the functions and tasks in those roles that would be expected in the setting of the services provided.